AMENDED IN SENATE APRIL 25, 2002

AMENDED IN SENATE MARCH 21, 2002

SENATE BILL No. 1344

Introduced by Senator Haynes

February 4, 2002

~~An act to add Section 733 to the Business and Professions Code, to amend Section 1367 of, and to add Sections 1234.5 and 1287 to, the Health and Safety Code, and to add Section 10119.1 to the Insurance Code,~~ *An act* relating to health care~~ coverage~~.

LEGISLATIVE COUNSEL'S DIGEST

SB 1344, as amended, Haynes. Health care~~ coverage~~: *denial of desired life-sustaining health care*.

Existing law ~~regulates persons licensed as healing arts practitioners and also regulates the operation of clinics, health facilities, health care service plans, and disability insurers. Under existing law, a violation of these provisions, other than those regulating the conduct of insurers, is generally punishable as a criminal offense~~*, the Health Care Decisions Law, authorizes a health care provider and a health care institution to decline to comply with a health care instruction or decision of a patient for specified reasons, including that it requires medically ineffective health care or health care that is contrary to generally accepted health care standards*.

This bill would ~~prohibit a licensed healing arts practitioner, a clinic, and a health facility from refusing to provide treatment to a person on the basis that it is futile if the person or his or her legal guardian desires that treatment. The bill would also prohibit a health care service plan and a health insurer from denying coverage for treatment on this basis.~~

~~Because the bill would specify additional requirements with respect to healing arts practitioners, clinics, health facilities, and health care service plans, the violation of which would be punishable as a criminal offense, it would create a new crime, thereby imposing a state-mandated local program.~~

~~The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.~~

~~This bill would provide that no reimbursement is required by this act for a specified reason.~~ *require the Health and Human Services Agency to convene a work group consisting of specified members. The bill would require the work group to obtain a copy of the policies of California health care institutions pertaining to the denial of desired life-sustaining health care and to study various issues regarding the implementation of those policies. The bill would also require the work group to report its findings and recommendations on designated issues to the Legislature prior to January 1, 2004.*

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: ~~yes~~ *no*.

The people of the State of California do enact as follows:

~~SECTION 1. Section 733 is added to the Business and~~

SECTION 1. (a) The Legislature finds and declares the following:

(1) A controversy currently exists as to whether health care providers and institutions are denying desired life-sustaining health care on the basis that the care is "futile," "inappropriate," "medically ineffective, "nonbeneficial," or "contrary to generally accepted health care standards."

(2) Section 4615 of the Probate Code defines "health care" as any care, treatment, or procedure to maintain, diagnose, or otherwise affect a patient's physical or mental condition.

(3) Except as provided in Sections 4734 and 4735 of the Probate Code, Section 4733 of that code requires a health care provider and a health care institution providing care to a patient to comply with an individual health care instruction of the patient and with a reasonable interpretation of that instruction made by a person then authorized to make health care decisions for the

patient and to comply with a health care decision made for the patient by a person then authorized to make those decisions for the patient to the same extent as if the decision had been made by the patient while having capacity to make health care decisions for himself or herself.

(4) Section 4734 of the Probate Code allows a health care provider to decline to comply with an individual health care instruction or health care decision for reasons of conscience and allows a health care institution to decline to comply with an individual health care instruction or health care decision if the instruction or decision is contrary to a policy of the institution that is expressly based on reasons of conscience, and the policy was timely communicated to the patient or to a person then authorized to make health care decisions for the patient.

(5) Section 4735 of the Probate Code allows a health care provider and a health care institution to decline to comply with an individual health care instruction or health care decision that requires medically ineffective health care or health care contrary to generally accepted health care standards applicable to the health care provider or institution.

(6) Section 4736 of the Probate Code requires a health care provider or health care institution that declines to comply with an individual health care instruction or health care decision to take all of the following actions:

(A) Promptly inform the patient, if possible, and any person then authorized to make health care decisions for the patient of the decision to decline the health care instruction or decision.

(B) Immediately make all reasonable efforts to assist in the transfer of the patient to another health care provider or institution that is willing to comply with the health care instruction or decision unless the patient or person then authorized to make health care decisions for the patient refuses assistance.

(C) Provide continuing care to the patient until a transfer can be accomplished or until it appears that a transfer cannot be accomplished.

(D) Continue appropriate pain relief and other palliative care.

(7) Existing law does not define "futile care," "inappropriate care," "medically ineffective care," "nonbeneficial care," or "care which is contrary to generally accepted health care standards."

(b) It is the intent of the Legislature that the Health and Human Services Agency convene a work group to determine the following matters:

(1) Whether patients are being denied desired life-sustaining health care and, if so, the basis for those denials.

(2) Whether health institutions have policies governing the denial of desired life-sustaining health care and, if so, the mechanism by which those policies are communicated to patients or to a person then authorized to make health care decisions for the patient.

SEC. 2. (a) The Health and Human Services Agency shall convene a work group that shall include, but not be limited to, the following members:

(1) A member appointed by the Medical Board of California.

(2) A member appointed by the State Department of Health Services.

(3) A member appointed by the Department of Managed Health Care.

(4) A member appointed by the Department of Insurance.

(5) One patient advocate appointed by the Majority Leader of the Senate.

(6) One patient advocate appointed by the Minority Leader of the Senate.

(7) One patient advocate appointed by the Majority Leader of the Assembly.

(8) One patient advocate appointed by the Minority Leader of the Assembly.

(9) Experts in the field of ethics and medicine.

(b) The work group shall obtain copies of the policies of California health care institutions that pertain to the denial of desired life-sustaining health care and determine the following matters:

(1) The policy of each institution regarding the denial of desired life-sustaining health care.

(2) The definitions of terms used in that policy.

(3) The procedures available to patients or their decisionmakers to resolve disputes regarding the denial of desired life-sustaining health care and the authority who makes the final decision if a dispute cannot be resolved.

(4) The number of patients, if any, who have been denied desired life-sustaining health care in California based upon a denial of care policy.

(5) The number of patients, if any, who have been denied desired life-sustaining health care that would be considered a generally accepted treatment protocol for the disease of the patient who was denied that care because of the patient's physical or mental condition, race, gender, sexual orientation, disability, age, or any other discriminatory basis, and, to the extent practicable, the basis of the denial.

(6) The number of patients, if any, or their decisionmakers who have used an independent medical review process or have initiated a legal action in order to obtain desired life-sustaining health care.

(7) Whether existing independent medical review, grievance, utilization review, and second opinion processes are adequate for patients or their decisionmakers who have sought review of the denial of desired life-sustaining health care decisions.

(c) (1) The work group shall prepare a report that includes, but is not limited to, the following matters:

(A) The results of its findings pertaining to the matters described in subdivision (b).

(B) Recommendations for amending existing state law to protect the right of patients to receive desired life-sustaining health care.

(C) Recommendations for civil penalties for the failure to comply with existing law.

(D) Recommendations for the definition of "futile care."

(2) The work group shall submit this report to the Legislature prior to January 1, 2004.

~~Professions Code, to read:~~

~~733. (a) Notwithstanding the provisions of Section 4735 of the Probate Code, no person licensed under this division shall refuse to provide treatment to a person on the basis that it is futile if the person or his or her legal guardian desires that treatment.~~

~~(b) A person who violates this section is guilty of a misdemeanor. All fines imposed pursuant to this subdivision shall be deposited into the General Fund.~~

~~(c) Nothing in this section shall be construed to require treatment that provides no medical benefit for the specific condition for which the person is being treated.~~

~~SEC. 2. Section 1234.5 is added to the Health and Safety Code, to read:~~

~~1234.5. (a) Notwithstanding the provisions of Section 4735 of the Probate Code, no clinic shall refuse to provide treatment to a person on the basis that it is futile if the person or his or her legal guardian desires that treatment.~~

~~(b) Nothing in this section shall be construed to require treatment that provides no medical benefit for the specific condition for which the person is being treated.~~

~~SEC. 3. Section 1287 is added to the Health and Safety Code, to read:~~

~~1287. (a) Notwithstanding the provisions of Section 4735 of the Probate Code, no health facility shall refuse to provide treatment to a person on the basis that it is futile if the person or his or her legal guardian desires that treatment.~~

~~(b) Nothing in this section shall be construed to require treatment that provides no medical benefit for the specific condition for which the person is being treated.~~

~~SEC. 4. Section 1367 of the Health and Safety Code is amended to read:~~

~~1367. Each health care service plan and, if applicable, each specialized health care service plan shall meet the following requirements:~~

~~(a) All facilities located in this state including, but not limited to, clinics, hospitals, and skilled nursing facilities to be utilized by the plan shall be licensed by the State Department of Health Services, where licensure is required by law. Facilities not located in this state shall conform to all licensing and other requirements of the jurisdiction in which they are located.~~

~~(b) All personnel employed by or under contract to the plan shall be licensed or certified by their respective board or agency, where licensure or certification is required by law.~~

~~(c) All equipment required to be licensed or registered by law shall be so licensed or registered and the operating personnel for that equipment shall be licensed or certified as required by law.~~

~~(d) The plan shall furnish services in a manner providing continuity of care and ready referral of patients to other providers at times as may be appropriate consistent with good professional practice.~~

~~(e) (1) All services shall be readily available at reasonable times to all enrollees. To the extent feasible, the plan shall make all services readily accessible to all enrollees.~~

~~(2) To the extent that telemedicine services are appropriately provided through telemedicine, as defined in subdivision (a) of Section 2290.5 of the Business and Professions Code, these services shall be considered in determining compliance with Section 1300.67.2 of Title 28 of the California Code of Regulations.~~

~~(f) The plan shall employ and utilize allied health manpower for the furnishing of services to the extent permitted by law and consistent with good medical practice.~~

~~(g) The plan shall have the organizational and administrative capacity to provide services to subscribers and enrollees. The plan shall be able to demonstrate to the department that medical decisions are rendered by qualified medical providers, unhindered by fiscal and administrative management.~~

~~(h) (1) All contracts with subscribers and enrollees, including group contracts, and all contracts with providers, and other persons furnishing services, equipment, or facilities to or in connection with the plan, shall be fair, reasonable, and consistent with the objectives of this chapter. All contracts with providers shall contain provisions requiring a fast, fair, and cost-effective dispute resolution mechanism under which providers may submit disputes to the plan, and requiring the plan to inform its providers upon contracting with the plan, or upon change to these provisions, of the procedures for processing and resolving disputes, including the location and telephone number where information regarding disputes may be submitted.~~

~~(2) Each health care service plan shall ensure that a dispute resolution mechanism is accessible to noncontracting providers for the purpose of resolving billing and claims disputes.~~

~~(3) On and after January 1, 2002, each health care service plan shall annually submit a report to the department regarding its dispute resolution mechanism. The report shall include information on the number of providers who utilized the dispute resolution mechanism and a summary of the disposition of those disputes.~~

~~(i) Each health care service plan contract shall provide to subscribers and enrollees all of the basic health care services~~

~~included in subdivision (b) of Section 1345, except that the director may, for good cause, by rule or order exempt a plan contract or any class of plan contracts from that requirement. The director shall by rule define the scope of each basic health care service that health care service plans shall be required to provide as a minimum for licensure under this chapter. Nothing in this chapter shall prohibit a health care service plan from charging subscribers or enrollees a copayment or a deductible for a basic health care service or from setting forth, by contract, limitations on maximum coverage of basic health care services, provided that the copayments, deductibles, or limitations are reported to, and held unobjectionable by, the director and set forth to the subscriber or enrollee pursuant to the disclosure provisions of Section 1363.~~

~~(j) No health care service plan shall require registration under the Controlled Substances Act of 1970 (21 U.S.C. Sec. 801 et seq.) as a condition for participation by an optometrist certified to use therapeutic pharmaceutical agents pursuant to Section 3041.3 of the Business and Professions Code.~~

~~Nothing in this section shall be construed to permit the director to establish the rates charged subscribers and enrollees for contractual health care services.~~

~~The director's enforcement of Article 3.1 (commencing with Section 1357) shall not be deemed to establish the rates charged subscribers and enrollees for contractual health care services.~~

~~(k) Notwithstanding the provisions of Section 4735 of the Probate Code, no plan shall deny coverage for treatment on the basis that it is futile if the enrollee or his or her legal guardian desires that treatment.~~

~~*(l) Nothing in subdivision (k) shall be construed to require treatment that provides no medical benefit for the specific condition for which the enrollee is being treated.*~~

~~SEC. 5. Section 10119.1 is added to the Insurance Code, to read:~~

~~10119.1. (a) Notwithstanding the provisions of Section 4735 of the Probate Code, no policy of health insurance shall deny coverage for treatment on the basis that it is futile if the insured or his or her legal guardian desires that treatment.~~

~~(b) Nothing in this section shall be construed to require treatment that provides no medical benefit for the specific condition for which the insured is being treated.~~

~~SEC. 6. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.~~

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